Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 17, 2024

Licensee
Alizah Family Services
4939 140th Street West
Apple Valley, MN 55124

RE: Project Number(s) SL35392015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

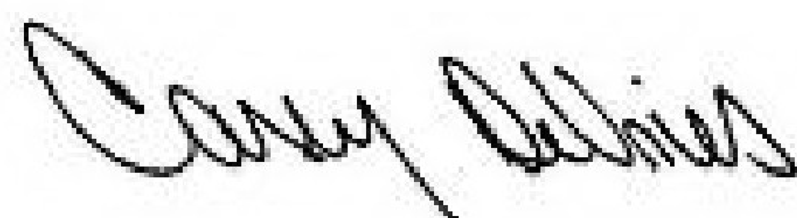
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35392	A. BUILDING: ______ B. WING ______	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIZAH FAMILY SERVICES	**4939 140TH STREET WEST APPLE VALLEY, MN 55124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34768015-0 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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Continued From page 2

cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on June 17, 2024, at approximately 11:30 a.m., the surveyor requested the licensee's staffing plan. Licensed assisted living director (LALD)-D provided the surveyor with an undated, Staffing, Direct-Care Staffing Plan and Daily Schedule document.

On June 17, 2024, at 11:45 a.m. during the entrance conference, the clinical nurse supervisor stated they did not complete the staffing plan. The staffing plan was done by the owners and the staffing schedule was revised every two weeks.

The licensee's undated, Staffing, Direct-Care Staffing Plan and Daily Schedule policy read,
"3. The RN in collaboration with the LALD have developed and implemented this staffing plan.
4. The staffing plan provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and will be adequate to address:
a. Each resident's needs as identified in the service plan and assisted living contract
b. Each resident's acuity level as determined by the most recent assessment or individualized review
c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises
d. The staffing plan will indicate if the assisted living has a secured dementia care unit

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0 470	Continued From page 3 e. Staff competency and training. 5. The staffing plan is evaluated for the appropriate staffing levels 6. The House Manager develop a 24-hour daily staffing schedule." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and	0 480		

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0 480	Continued From page 4 Beverage Establishment Inspection Report (FBEIR) dated June 17, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 5 by: Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Plan reviewed on January 2024, lacked evidence of the following required contents: - policies and procedures for volunteers; - roles under a waiver declared by secretary; - quarterly review of the missing resident plan quarterly. On June 18, 2024, at 1:15 p.m., licensed assisted living director (LALD)-D stated they were not aware they were required to review the missing resident plan quarterly. In addition, LALD-D further stated they were not aware the contents listed above were required. The licensee's undated, Emergency Preparedness policy read, "A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110."	0 680		

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0 680	Continued From page 6 Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide adequately rated portable fire extinguishers as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 790		

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0 790	Continued From page 7	0 790		

resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On June 18, 2024, at 9:00 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. It was observed that the provided fire extinguisher on the lower level was 1-A:10-BC (size) rated and did not have the minimum required 2-A:10-B:C rated fire extinguisher.

On June 18, 2024, at 9:30 a.m., LALD-D verified the facility did not have an appropriate size fire extinguisher.

TIME PERIOD FOR CORRECTION: Seven (7) days

01370 SS=F — 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn — 01370

(a) Training and competency evaluations for all unlicensed personnel must include the following:
(1) documentation requirements for all services provided;
(2) reports of changes in the resident's condition to the supervisor designated by the facility;
(3) basic infection control, including blood-borne pathogens;
(4) maintenance of a clean and safe environment;
(5) appropriate and safe techniques in personal hygiene and grooming, including:

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01370	Continued From page 8 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for one of two unlicensed personnel (ULP-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01370		

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01370	Continued From page 9	01370		

Continued From page 9

or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-A was hired on February 19, 2024, to provide direct cares to residents.

On June 18, 2024, at 12:26 p.m., the surveyor observed ULP-A administer oral medications to R2.

ULP-A's employee record lacked the following competency evaluations:
- standby assistance techniques and how to perform them.

On June 18, 2024, at 12:05 p.m., clinical nurse supervisor (CNS)-C stated they were aware of the requirement to train ULP on the above-mentioned topic, and they did not know how it was missed.

The licensee's undated, Assisted Living Orientation policy read, " 5. Training and skills demonstration for ULPs who are not NARs {nursing assistant registered]: In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration:
- Standby assistance techniques"

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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01620	Continued From page 10	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee also failed to use the uniform assessment tool with all the required contents for one of one resident (R1), This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01620		

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01620	Continued From page 11	01620		

or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1 was admitted on September 9, 2022, and began receiving assisted living services.

R1's service plan signed April 1, 2024, indicated R1 received assistance with medication administration, bathing, hygiene /grooming, treatments, positioning and transfer, wheeling and socialization.

R1's 90-day Service Plan Reassessment and Monitoring- 30 Day Reassessment of Service Plan dated April 4, 2024, lacked the following areas required on the uniform assessment tool:
A) the resident's personal lifestyle preferences;
(1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life;
(2) spiritual and cultural preferences; and
(3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order;
B) activities of daily living;
(1) toileting pattern, bowel, and bladder control;
(2) dressing, grooming, bathing, and personal hygiene;
(3) mobility, including ambulation, transfers, and assistive devices; and
(4) dental status, oral care, and assistive devices and dentures, if applicable;
C. instrumental activities of daily living, including:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 12	01620		

(1) ability to self manage medications;
(2) housework and laundry; and
(3) transportation;
D. physical health status, including:
(1) a review of relevant health history and current health conditions, including medical and nursing diagnoses;
(2) infectious conditions;
(3) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each:
(a) the reason taken;
(b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues;
(c) the dosage;
(d) the frequency of use;
(e) the route administered or taken;
(f) any difficulties the resident faces in taking the medication;
(g) whether the resident self administers the medication;
(h) the resident's preferences in how to take medication;
(i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and
(j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications;
(5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post acute care facility;
(6) a review of any reports from a physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35392	A. BUILDING: ______ B. WING ______	06/18/2024

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ALIZAH FAMILY SERVICES	4939 140TH STREET WEST APPLE VALLEY, MN 55124

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01620	Continued From page 13 therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; and (7) weight E. communication and sensory capabilities, including: (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; F. pain, including: (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and non-medication alternatives; G. skin conditions; H. nutritional and hydration status and preferences; I. list of treatments, including type, frequency, and level of assistance needed; J. nursing needs, including potential to receive nursing-delegated services; K. risk indicators, including: (1) history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and	01620		

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01620	Continued From page 14	01620		

(9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician;
L. who has decision-making authority for the resident, including:
(1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and
(2) the scope of decision-making authority of a substitute decision maker under sub item (1); and
M. the need for follow-up referrals for additional medical or cognitive care by health professionals.

On June 18, 2024, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-C stated they use the same assessment tool for all of the licensee's residents. CNS-C stated they were not aware the above listed contents were required, and stated they will fix it.

The licensee's undated, Initial and On-Going Assessment of Residents policy read, "A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. Current and historical records and information are reviewed to the extent they are made available to the RN and if the RN is aware of these records".

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

Each treatment or therapy administered by an

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01960	Continued From page 15 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted and began receiving assisted living services on September 9, 2022, with diagnoses including morbid obesity, diabetes, hypertension, atrial fibrillation, deep vein thrombosis with pulmonary embolism, congestive heart failure, and obstructive sleep apnea. R1's service plan signed April 1, 2024, indicated R1 received assistance with medication administration, bathing, hygiene /grooming, treatments, positioning and transfer, wheeling	01960		

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01960	Continued From page 16 and socialization. On June 18, 2024, at approximately 11:45 a.m., the surveyor observed R1 receiving oxygen via nasal cannula by use of an oxygen concentrator. The surveyor also observed a Trilogy 100 ventilator machine in R1's room. R1's record lacked a prescriber order for R1's oxygen treatment or ventilator use. On June 18, 2024, at 12:05 p.m. licensed assisted living director (LALD)-D provided the surveyor a document that contained information requested by the surveyor. LALD-D indicated in writing they did not have evidence of a R1's prescriber order for oxygen. On June 18, 2024, at approximately 12:05 p.m., clinical nurse supervisor (CNS)-C stated they did not document on the ventilator or oxygen treatment. CNS-C stated they turned the ventilator on and off, and checked R1's oxygen level when there was a change of condition. R1's medical record (MAR) dated June 1-18, 2024, included the following order to be documented "Taper down oxygen to keep oxygen saturation > 90%" On June 18, 2024, at 1:20 p.m., the surveyor inquired to know how the licensee executed the above-mentioned order. CNS-C stated they did not have an signed prescriber's order to check oxygen. They administered oxygen to R1 when R1 had symptoms. On June 18, 2024, at 1:25 p.m., unlicensed personnel (ULP)-A stated they did not have an order to check oxygen or to document. The	01960		

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01960	Continued From page 17	01960		

surveyor observed ULP-A's initials on the MAR for the above mentioned order to taper oxygen for the day shift on June 18, 2024. The surveyor inquired to know what they did to check off the MAR with their initial as completed for the taper oxygen down order. ULP-A stated they make sure the oxygen tank is on and ready for R1's use. They give it to R1 and take it off per R1's request. ULP-A further stated night staff assisted R1 with the ventilator.

The licensee's undated, Documentation of Medication, Treatment and Therapy Management Services policy read, "RNs, LPNs, and ULPs will appropriately document all medications, treatments, and therapy management services provided to residents including documentation of PRN medications and documentation of requesting and receiving prescription refills".

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

This MN Requirement is not met as evidenced by:

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01970	Continued From page 18 Based on observation, interview, and record review, the licensee failed to ensure prescriber's orders were in place for treatments for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted and began receiving assisted living services on September 9, 2022, with diagnoses including morbid obesity, diabetes, hypertension, atrial fibrillation, deep vein thrombosis with pulmonary embolism, congestive heart failure, and obstructive sleep apnea. R1's service plan signed April 1, 2024, indicated R1 received assistance with medication administration, bathing, hygiene /grooming, treatments, positioning and transfer, wheeling and socialization. On June 18, 2024, at approximately 11:45 a.m., the surveyor observed R1 receiving oxygen via nasal cannula by use of an oxygen concentrator. The surveyor also observed a Trilogy 100 ventilator machine in R1's room. R1's record lacked a prescriber order for R1's oxygen treatment or ventilator use. On June 18, 2024, at 12:05 p.m. licensed	01970		

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01970	Continued From page 19	01970		

assisted living director (LALD)-D provided the surveyor a document that contained information requested by the surveyor. LALD-D indicated in writing they did not have evidence of a R1's prescriber order for oxygen.

On June 18, 2024, at approximately 12:05 p.m., clinical nurse supervisor (CNS)-C stated they did not have prescription for the oxygen treatment or the ventilator. CNS-C stated when the provider prescribed the treatments mentioned above, they may have sent it to the supply company and the supply company did the settings for the ventilator and sent it to the licensee. The surveyor inquired how many liters of Oxygen was being administered and how they determined how many liters to administer to R1. CNS-C stated they may have gotten the information from the "hospital paperwork to give two liters of oxygen". CNS-C was unable to provide any hospital paperwork with the above-mentioned order.

The licensee's undated, Medication, Treatment and Therapy Reminders Policy read, "residents will receive medication, treatment, and therapy reminders per RN [registered nurse] assessment and provider orders".

No further information provided.

TIME PERIOD FOR CORRECTION: Seven (7) days.

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/17/24*
Time: 12:40:55
Report: 1004241159

Food and Beverage Establishment Inspection Report

Location:
2 Caring Hands Inc
4939 140th Street West
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0038922
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526831113
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs
3-302.11A(1) ***** Priority 1 *****
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
RAW GROUND BEEF PATTIES FOUND STORED ABOVE PRODUCE IN THE REFRIGERATOR. ENSURE ALL RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS. *CORRECTED ON SITE.
Comply By: 06/17/24

4-300 Equipment Numbers and Capacities
4-302.12B ***** Priority 2 *****
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
THERMOMETER(S) ON SITE DO NOT HAVE A SMALL DIAMETER PROBE. PROVIDE A THERMOMETER WITH A SMALL DIAMETER PROBE FOR USE WITH THIN FOODS FOR ACCURATE TEMPERATURES.
Comply By: 06/17/24

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CURRENT STATE CERTIFIED FOOD PROTECTION MANAGER. OPERATOR STATED THEY WERE IN THE PROCESS OF OBTAINING THE STATE CERTIFICATION.
Comply By: 06/17/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO INTERNAL THERMOMETER LOCATED IN THE REFRIGERATORS. PROVIDE AND MAINTAIN IN THE WARMEST PART OF THE EQUIPMENT (IN OR NEAR THE DOOR).

Comply By: 06/17/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO POSTER/SIGNAGE AT THE HANDWASHING SINK. PROVIDE AND MAINTAIN.

Comply By: 06/17/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	3

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY DEE MOSISSA.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL

FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATORS AND WITH THE NURSE EVALUATOR, DEE.

*FLOORS ARE TREATED WOOD, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE SMOOTH STONE AND CABINETS ARE PAINTED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.
.
*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004241159 of 06/17/24.

Certified Food Protection Manager: NONE

Certification Number: ______________ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: ______________________________
PAUL RAMCHARIT

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us